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AMA Submission to the review of national aged care quality regulatory processes

Background

The Oakden report has shed light on a wide range of issues facing aged care. Our members have reported that the occurrences at Oakden Older Mental Health Service (Oakden) were not isolated incidents, and this indicates a problem with the current aged care system. The proportion of Australians 65 years of age and over is predicted to increase to 18 per cent by 2026[1]. It is also predicted that 900,000 Australians will have dementia by 2050 (342,800 as at 2015)[2]. In light of these predictions in the context of residential aged care facilities (RACFs), it is evident that the health care needs of residents are increasing in complexity. Indeed, the majority of Aged Care Funding Instrument (ACFI) assessments indicate a 'high' need of care across all three assessment categories (activities of daily living, behaviour, and complex health care)[3]. The Government must ensure that the sector has the capacity and capability to provide quality care for this growing, more complex, ageing population.

The issues at Oakden were brought to the attention of the Northern Adelaide Local Health Network (NALHN) when a client was admitted to an Emergency Department with significant bruising to his hip. A person's health status is a significant identifier for the quality of an aged care facility or home service, and when serious health issues arise, this is when aged care issues are commonly noticed. Medical practitioners – whether at the Emergency Department, or consulting patients' at an aged care facility – may have a unique opportunity to identify issues with the quality of an aged care home or signs of elder abuse. Medical practitioners are also the second highest profession Australians trust[4], and should be considered part of the aged care workforce to increase quality of care.

[1] https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/12_2016/2015-16_report-on-the-operation-of-the-aged-care-act-1997.pdf
[2] http://www.aihw.gov.au/dementia/
[3] Australian Institute of Health and Welfare (2015) *Residential aged care and home care 2014-15 – Care needs in residential aged care.*
[4] https://www.roymorgan.com/findings/7244-roy-morgan-image-of-professions-may-2017-201706051543

Many points made in this submission have been previously made by the AMA, and they are not newly arising issues in the aged care sector. We have been advocating for some time to ensure medical and nursing care for older Australians, including lodging submissions to the multiple aged care reviews that have occurred recently. In this submission, we argue that:

- Medical practitioners should be included as part of the aged care workforce to ensure residents of aged care facilities are receiving quality care.
- Aged care needs funding for the recruitment and retention of registered nursing staff and carers, specifically trained in dealing with the issues that older people face.
- The aged care sector needs a contemporary system that embraces information technology (IT) infrastructure for patient management.
- A contemporary IT system for medication management will reduce the risk of polypharmacy, and in turn reduce the likelihood of cognitive impairment, delirium, frailty, falls, and mortality in RACFs.
- There needs to be clear, specific, and confidential complaints referral pathways in each RACF so information on complaints processes are easily accessible to both residents and staff.
- There needs to be increased awareness of mental health issues to include funding for appropriate mental health services in the ACFI assessment process.
- The aged care system needs an overarching, independent, Aged Care Commissioner that provides a clear, well-communicated, governance hierarchy that brings leadership and accountability to the aged care system.

Many of these issues need to be reflected in specific accreditation standards that have a strong focus on health. In particular, an 'access to medical care' standard should be introduced.

The accreditation framework

To receive funding from the Federal Government, an aged care facility must pass accreditation standards which are assessed by the Australian Aged Care Quality Agency (AACQA)[5]. We recognise that these standards will vary with the introduction of the single set of aged care quality standards[6], however there are several required improvements that should be included in the new standards. The current accreditation standards:

> "…do not provide an instruction or recipe for satisfying expectations but, rather, opportunities to pursue quality in ways that best suit the characteristics of each individual residential care service and the needs of its care recipients. It is not expected that all residential care services should respond to a standard in the same way."[7]

For some standards, a flexible approach is adequate, as different services have different capabilities and capacities. However, this may lead to inconsistencies between each assessor, or the assessment process not picking up on vital signs of incompetence.

[5] http://www.aacqa.gov.au/consumers/for-providers
[6] https://agedcare.health.gov.au/quality/single-set-of-aged-care-quality-standards
[7] https://www.legislation.gov.au/Details/F2014L00830

Standards that relate to medical care should not be subject to interpretation to ensure quality care is received and so RACFs are aware of their specific responsibilities. Residents should have access to, and their medical needs met by, qualified medical practitioners. The standards '2.4 – access to clinical care' and is not adequate to ensure quality health care.

To rectify this, the standards should incorporate an 'access to medical care' standard. Rather than vague standards that say RACFs should ensure compliance with all relevant legislation, a medical care standard should reflect aspects of the *National Safety and Quality Health Service Standards*[8]. People living in aged care facilities should have access to the same quality health services as other Australians. The AMA has been advised that currently, RACFs (with the exception of facilities that provide acute services) do not have to comply with these standards.

Under a medical care standard, there are other aspects that should be considered to achieve quality care, as described below.

Access to staff

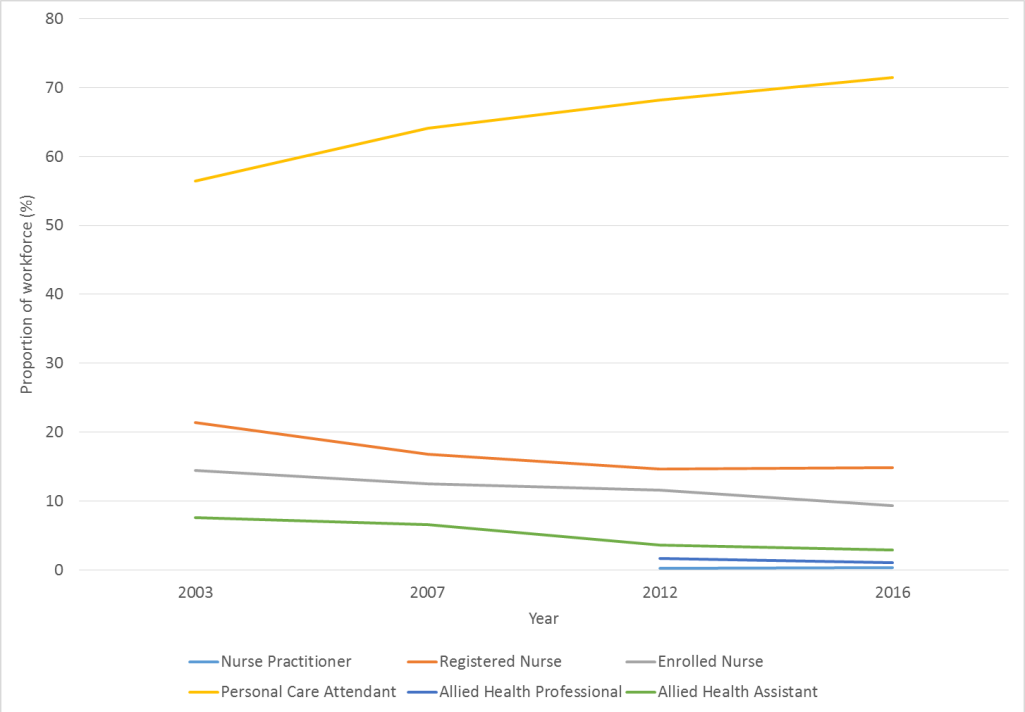

Figure 1: The proportion of Full Time Equivalent employee types in the aged care workforce. Data source: Mavromaras et al (2016) The aged care workforce, 2016. Department of Health

There has been a decreasing trend in the proportion of registered and enrolled nurses in the aged care workforce (Figure 1). Our members have reported cases where registered nurses are being replaced by junior personal care attendants, and some RACFs do not have any nurses staffed after hours. This presents significant communication difficulties, as our members have advised that there is on occasion no nurse or appropriate staff member available to discuss their patient's requirements. Further, a recent survey identified low staffing levels in residential aged care as the main cause of missed care (e.g. not responding to bed calls within five minutes,

[8]Australian Commission on Safety and Quality in Health Care (2012) *National Safety and Quality Health Service Standards*.

checking vital signs etc.)[9]. This is also reflected in the Oakden report – where there were very low levels of nursing staff, and nurses were being replaced by personal care attendants[10].

The Government must ensure that aged care facilities are not restricted due to a workforce shortage. The decline in the proportion of nurses and enrolled nurses needs to be reversed to ensure residents are provided with timely and appropriate clinical care. This is critical to the success of the aged care system. The absence of a criteria for a minimum nurse to patient ratio in the '2.5 specialised nursing care needs' accreditation standard has allowed the shift in proportions. This has placed additional pressure on nurses and medical practitioners and has potentially led to increased transfers to the Emergency Department (ED).

The accreditation standards should demonstrate a ratio of suitably trained nurses to patients at any one time to ensure people living in RACFs with complex needs are receiving appropriate care. There is considerable evidence to suggest that implementing nurse-to-patient ratios significantly improves the quality of patient care in hospitals[11], and the Queensland Government has acted on this evidence by introducing nurse-to-patient ratios in health facilities[12]. Currently, our members advise that ratios vary considerably across each RACF, and that the registered nurse staffing hours do not reflect whether there are high or low care patients in the facility. This recommendation has been raised several times, through the Australian Nursing and Midwifery Federation, and in both the AMA's submission[13] to the *Senate Inquiry into the future of Australia's aged care workforce*, and as a main discussion point in the Inquiry's report[14].

General Practitioner employment arrangements

The current policy settings do not support GPs working after hours, neither does it acknowledge the benefits of continuity of care. Our members report that continuity of care goes generally unacknowledged in many RACFs and a resident's management plan is not well known. This creates an environment where the default step for RACF staff may be to refer the patient to an ED. In a study of 2880 residents of aged care facilities presented to the ED, one third of presentations could have been avoided by incorporating primary care services[15]. Reasons for decisions to transfer residents to an ED include limited skilled staff, delays in GP consultations, and a lack of suitable equipment.

The AMA Member 2015 Aged Care Survey showed that non-contact time (such as responding to phone calls and faxes from RACF staff and patient relatives) with patients has also increased. One concept worth considering is an MBS item for phone consultations with a nurse or carer

[9] Henderson et al (2016) *Missed care in residential aged care in Australia: An exploratory study*, Collegian.
[10] Groves A, Thomson D, McKellar D and Procter N. (2017) *The Oakden Report.* Adelaide, South Australia: SA Health, Department for Health and Ageing. p65.
[11] Needleman et al (2002) *Nurse-staffing levels and the quality of care in hospitals*. The New England Journal of Medicine. 346:22. p1715-1722
[12] https://www.health.qld.gov.au/ocnmo/nursing/nurse-to-patient-ratios
[13] https://ama.com.au/submission/ama-submission-senate-community-affairs-inquiry-future-australia%E2%80%99s-aged-care-sector
[14] http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareWorkforce45/Report
[15] Morphet et al (2015) *Resident transfers from aged care facilities to emergency departments: can they be avoided?*. Emergency Medicine Australasia. 27:5, p412-418

from a RACF to incentivise doctors to be on call after hours. This could in turn increase the number of doctors who make themselves available out of normal business hours and reduce costs in comparison to reimbursing a GP physically-attended consultation. In addition, the care of patients' regular GP would avoid unnecessary referrals to the ED and the associated triage issues.

Older people are often burdened with complex and multiple medical disorders that warrant the regular attention of medical practitioners and quality nursing care, which in turn warrants consideration in the context of aged care reforms. Results from the AMA Member 2015 Aged Care Survey conclude this is not occurring, and the lack of both financial and staff support from the Government to provide quality aged care services must be addressed.

Appropriate support for medical services, including limited forms of pharmacology and pathology, in RACFs, will improve residents' access to medical care, and can reduce unnecessary pressure for, and counter-productive utilisation of, acute services. Investment in medical services in RACFs will lead to a more efficient health system.

The Government should consider the merits of different models of providing medical care services within RACFs. Currently, many residents have minimal choice in deciding who their GP will be once they enter a RACF. Patients should be able to decide whether they stay with their existing GP, or transition to the in-house GP if available. Alternate models should expand the opportunities for medical practitioners working in an aged care facility and support practitioners to provide ongoing medical care. This has the potential to reduce unnecessary transfers to more expensive forms of care such as hospitals, and also reduce the risk of medical neglect going unnoticed for long periods of time.

In addition to the downshifting of staff mentioned earlier, there is some anecdotal evidence that an increasing number of RACFs are using nurse practitioners (NPs) instead of GPs to tend to residents. This will fragment care; NPs are able to carry out a subset of tasks that make up only part of the tasks a GP can undertake, however this will result in the duplication of services to patients. We value the critical role that nurses play in the aged care sector, however it is imperative that any such services are provided in collaboration with the patient's usual GP, detailed in a collaborative agreement that specifies the role of the NP and how they will work and communicate with the patient's usual GP.

It is important there is clear regulation and understanding around the use of NPs to ensure this method of relieving workforce pressures does not undermine the medical quality of care that medical practitioners provide, change the scope of practice, or subject residents to over-servicing.

Access to the patient

There needs to be a specific standard on the management of medical records that aligns with the Royal Australian College of General Practitioners standards on patient health records[16]. Currently, the standard '1.8 Information systems' ambiguously outlines that there should be

[16] http://www.racgp.org.au/your-practice/standards/standards4thedition/practice-services/1-7/patient-health-records/

effective information management systems in place. Medical records should be based through an efficient and accurate electronic system that is accessible to all staff and visiting medical practitioners to avoid the 'doubling up' of records and the possibility of missing information. A study[17] published in 2016 highlighted that only 37.4 per cent of RACFs used an electronic health record (EHR) system, with the remaining 62.6 per cent relying on paper-based records. They found that compliance with the accreditation standards in EHR users was of a significantly higher proportion than those who relied on paper-based records.

This standard currently only applies to management and staff of an RACF. Medical practitioners should also have full time ready access to these information management systems, including clinical files on a contemporary clinical software system. This includes software that is user-friendly and appropriate to the needs of general practitioners, improved electronic interface between pharmacy services and RACF records, and/or support for remote access to the practitioner's medical records. The software should not require multiple logins, so as to increase efficiency. The My Health Record, provided all IT security requirements are met, should sync with aged care software systems. This will achieve better communication between the care team, faster access to hospital discharge summaries, fewer medication errors, and better access to Advance Care Directives.

The My Aged Care Gateway should be interoperable with clinical software and the My Health Record. The My Aged Care Gateway referral form needs to be integrated into general practice clinical software so that the form can be auto-populated, attached to the patient record, and securely sent.

Access to the facility

There is a growing tendency to build facilities in the outer growth corridors or 'urban fringe' of metropolitan areas which further adds to the time spent by medical practitioners away from their surgeries. This also forces people to move further away from their community and reduces the likelihood of retaining their usual GP, which in turn breaks continuity of care.

A car parking space and 24-hour access through the main entry should be available to medical practitioners to ensure they have access to their patients quickly and whenever it is required. This suggestion requires no additional cost to the facility and could be easily implemented.

The standard '1.7 – Inventory and equipment', should include access to a suitably equipped medical treatment room. Treatment usually has to be provided in a shared room where there is a lack of privacy for the patient and no equipment for the treating doctor, limiting the medical treatment that can be provided in that setting. Currently, this standard states that there should be appropriate goods and equipment available for quality service delivery[18], however this is not occurring for the goods and equipment medical professionals require to provide a quality service.

[17] Jiang et al (2016) *The impact of electronic health records on risk management of information systems in Australian residential aged care homes*. J Med Syst. 40:204.
[18] https://www.aacqa.gov.au/assessors/PocketguideSeptember2014updatedforweb.pdf

Accreditation training and quality improvement

The aged care sector is heavily regulated and is currently going through significant reform[19], so it is difficult for the sector to keep track of all relevant legislation, policies and guidelines. The accreditation standards however give vague indications to RACFs on how to achieve adequate care. Regulations and standards in the aged care sector needs to be loose in areas that will improve innovation and quality in the sector, but not where medical care is involved. We hope to see standards refined through the development of a single set of aged care quality standards.

Currently, the AACQA runs workshops to assist RACFs in understanding their accreditation requirements – costing (post July 2017) $572 per participant, or $5280 for an AACQA representative to run the workshop in-house[20]. Training should be more financially accessible as many RACFs do not have the resources or capacity to attend costly workshops. The AMA agrees with the recommendation outlined in the report on the *Senate Inquiry into the future of Australia's aged care workforce*[21] that there should be support mechanisms in place to assist RACFs and aged care services to access quality training such as this to ensure staff are aware of their responsibilities.

Spot checks and review processes

Spot checks (i.e. unannounced site visits) are important tools for quality improvement and aim to be an educative experience for RACFs. It is important that spot checks remain to be just this to avoid a sense of fear in RACF staff that the process intends to 'catch out' RACFs not complying with standards. This could introduce a defensive, secretive culture of 'us vs them' and would not contribute to quality improvement. It is also important that spot checks do not take nurses and staff away from their duties of care in the RACF.

A Cost Recovery system will be introduced from the 1 July 2018 where aged care service providers are to pay for these unannounced visits[22]. This will only add pressure to services that are already struggling with their work capacity due to a lack of adequately trained staff and limited resources. Further, RACFs must undergo spot checks as part of the process to receive funding from the Government. Charging the RACF to undergo a process required to receive funding means that the RACF is essentially receiving less funding from the Government – they are spending funds to get funds.

Our members have also observed that the review process has a great focus on paperwork compliance addressed in Standard 1 rather than the major indicators of quality care in Standards 2 and 3. While management systems within the RACF are important, members have observed that RACF staff are worried about failing accreditation over a minor documentation compliance issue and instead focus on this rather than providing care to patients. The process should ensure that quality of care is considered a more essential indicator of quality than the existence of paperwork.

[19] https://agedcare.health.gov.au/aged-care-reform
[20] https://www.aacqa.gov.au/providers/education/courses-and-workshops/understanding-accreditation
[21] Community Affairs References Committee (2017) *Future of Australia's aged care workforce.*
[22] https://www.aacqa.gov.au/providers/cost-recovery/cost-recovery-consultation#public-consultation

The complaints handling process

The Government has recently introduced an independent Aged Care Complaints Commissioner to replace the former Aged Care Complaints Scheme. There has been an 11 per cent increase in the number of complaints from the first six months of 2015 to the first of 2016, however this could be due to increased awareness of the new Commissioner or an improved complaints process[23]. While the new complaints process is in its early days, our members have reported that the process has improved significantly since its implementation.

While the Government's complaints process is seeing improvements, there also needs to be a focus on the RACF's internal complaints process. Accreditation standard '1.4 – comments and complaints' implies that the RACF needs to have mechanisms in place that "each care recipient (or his or her representative) and other interested parties have access to internal and external complaints mechanisms[24]." There needs to be clear, specific complaints referral pathways in each RACF so information on complaints is easily accessible to both residents and staff.

The culture in many RACFs discourages making complaints, and this was especially seen at Oakden – where staff complaints were answered with bullying and harassment from management. The Government needs to ensure that the privacy and confidentiality of both aged care staff and consumers are protected when making a complaint.

Standards of care in RACFs

Training of aged care staff

It has been reported to the AMA that many aged care staff do not have to appropriate training to properly handle the major issues facing the elderly, such as behavioural conditions, falls prevention, pressure sore prevention, and pain management. We have been informed that this can lead to an increase in medication use.

Some of our members are concerned that aged care staff are requesting sedation of residents so they are easier to handle. Restraints such as sedation should only be prescribed where any potential risk or harm caused by the restraint itself is less than the risk of the patient not being restrained. They should always be considered a last resort. Providing care should ensure the safety, wellbeing and dignity of the patient and ensure a medical practitioner assesses the patient for any underlying behavioural conditions. Aged care staff should be properly trained on the ethical, medical and legal issues that can arise from using a restraint, and also educated on ways to improve the aged care environment through ensuring a friendly physical space, and through social and staffing structures.

[23] Aged Care Complaints Commissioner (2016) *Annual Report 1 July 2015-30 June 2016*.
[24] https://www.aacqa.gov.au/providers/residential-aged-care/resources/brocah0011accreditationstandardsfactsheetenglishv14.1.pdf

Culturally and Linguistically Diverse (CALD) individuals

Australia has seen a rise in the number of migrants. In 2013, 32 per cent of the Australian population (5.8 million people) were born overseas[25]. Projections for 2021 suggest that the older population will comprise 30 per cent of people born in a country other than Australia[26]. This presents a major challenge to incorporate different cultures into Aged Care, and communicate with individuals who may have low levels of English literacy.

In the case of Aboriginal and Torres-Strait Islander populations, it is important to ensure RACFs are culturally aware and informed, similar to the cultural understanding seen in Aboriginal Community-controlled Health Service. This will ensure smooth transition between the health system and the aged care provider.

Our members have recently highlighted the communication difficulties both with CALD staff and residents of RACFs, and more awareness of the services and training available to staff is required if CALD residents are to receive equitable aged care.

Polypharmacy in RACFs

Polypharmacy (the use of multiple (five or more) medicines) can cause cognitive impairment, delirium, frailty, increase the chance of falls, and mortality to name a few. This in turn increases the number of visits to the emergency department[27]. One of the disturbing issues at Oakden was that patients were receiving incorrect doses of medication. For example, one resident was given 10 times the intended amount of insulin every day for three days. This was not reported in any way[28]. Polypharmacy is an issue that occurs nation-wide, with reports of 20-30 per cent of hospital admissions over the age of 65 being medication-related, and studies suggesting that up to 63 per cent of RACF residents take nine or more medications regularly[29].

The standard '2.7 – Medication management' should include specific guidelines around medication reviews that align with the *National Strategy for Quality Use of Medicines*[30]. There also needs to be training for aged care staff and awareness of protocol relating to adverse reactions to medicines. State governments need to contribute funding to regular medication reviews – currently the National Aged Care Quality Indicator Programme does not include a medication quality indicator[31]. This funding would result in significant savings for both the

[25] Australian Bureau of Statistics (2013) *Characteristics of Recent Migrants* [online http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/6250.0/ accessed 23/11/2016]]

[26] Department of Social Services (2015) *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*

[27] http://www.nps.org.au/topics/ages-life-stages/for-individuals/older-people-and-medicines/for-health-professionals/polypharmacy

[28] Groves A, Thomson D, McKellar D and Procter N. (2017) *The Oakden Report.* Adelaide, South Australia: SA Health, Department for Health and Ageing. p85-86.

[29] Sluggett et al (2017) *Medication management policy, practice and research in Australian residential aged care: current and future directions.* Pharmacological Research. 116: p27-35.

[30] Commonwealth of Australia (2002) *The national strategy for quality use of medicines*. https://www.health.gov.au/internet/main/publishing.nsf/Content/8ECD6705203E01BFCA257BF0001F5172/$File/natstrateng.pdf

[31] Sluggett et al (2017) *Medication management policy, practice and research in Australian residential aged care: current and future directions.* Pharmacological Research. 116: p27-35.

patient, the RACF, and hospitals – as a reduction in polypharmacy has been found to significantly reduce the costs of care[32]. For example, the number of medications a patient takes predicts the risk of an Adverse Drug Event (ADE), and, when they occur, ADE's contribute to over 10 per cent of a patient's health care costs[33].

Currently, aged care providers are spending their limited time on communicating with GPs and pharmacists about medication issues. For example, one study found that 11 per cent of RACF staff spent more than half an hour per shift engaging with the pharmacy, and 13 per cent engaging with a GP (indeed as previously mentioned, our members have reported an increase in calls from RACF staff in the AMA Member 2015 Aged Care Survey). Further, a recent study showed that the participating healthcare professionals (medical practitioners, nurses, pharmacists, a dentist, and a physiotherapist) experienced significant barriers to implementing a structured review system for their patients. Reasons included a lack of user-friendly medical decision-making tools (and a lack of awareness for such tools), a large workload, an absence of individual responsibility of care, and difficulties that come with coordinating continuity of care[34].

Residential Medication Management Reviews (RMMRs) are available to permanent residents of government-funded RACFs[35] and are an important review and safety tool. However, RMMRs are becoming sparse. Some members have reported these are only occurring every two years, and that many patients are prescribed medication for behavioural issues when unnecessary in order to make them easier to handle. RMMRs should occur annually and on an as-needed clinical basis to ensure medications are not harming the patient.

Other attempts at reducing polypharmacy in RACFs include the national residential medication chart introduced to standardise the method of prescribing in 2014. Trial results of the medication chart indicated that it reduced medication errors and total prescribing[36], but there appears to have been limited uptake for this tool because it is still only largely paper-based.

Aged care facilities require improved IT systems that are interoperable with the My Health Record, namely its Medication Management feature, to ensure aged care staff have the tools in place to effectively communicate with all relevant stakeholders to prevent the risk of adverse reactions to using multiple medications. This adds to our previous argument that aged care services need significant uptake of contemporary and interoperable IT systems to achieve quality information management systems.

[32] Kojima et al (2012) *Reducing Cost by Reducing Polypharmacy: the polypharmacy outcomes project*. Journal of the American Medical Directors. 13:9 p818

[33] Scott et al (2014) *First do no harm: a real need to deprescribe in older patients*. The Medical Journal of Australia. 201:7 p390

[34] Namara, M et al (2016) *Health professional perspectives on the management of multimorbidity and polypharmacy for older patients in Australia.* Age and Ageing.

[35] http://www.health.gov.au/internet/main/publishing.nsf/Content/rmmr-factsheet

[36] Sluggett et al (2017) *Medication management policy, practice and research in Australian residential aged care: current and future directions.* Pharmacological Research. 116: p27-35.

Mental Health in Aged Care Facilities

In 2013, the Australian Institute of Health and Welfare (AIHW) found that 52 per cent of permanent aged care residents had symptoms of depression. Further, 73 per cent of residents with symptoms of depression had higher care needs compared to residents without symptoms of depression (53 per cent) [37]. Whilst on average the prevalence of mental illness lowers as an individual ages, there is only a slight decrease in the prevalence of high or very high psychological distress[38]. This data identifies mental health as a major issue affecting the quality of life for residents of aged care facilities.

Under the *Better Access to Mental Health Care* initiative, patients can claim Medicare rebates for mental health services provided by or through a GP[39]. They include GP Mental Health Treatment items where GPs undertake early intervention, assessment and management of patients with mental disorders, and include referral pathways from GPs for treatment by psychiatrists, clinical psychologists and other allied mental health workers. These items are not available to residents of aged care facilities.

Aged care residents have not been able to access the full range of MBS items for mental health treatment including access to psychological services under the *Better Access* initiative because it was considered their mental health care needs were covered under existing government funding for aged care, through the Aged Care Funding Instrument (ACFI) assessment (under the Behaviour Supplement, which assesses needs based on characteristics such as cognitive skills, behaviour and depression).

There needs to be an increase in awareness for including mental health as a factor when completing an ACFI assessment, and for incorporating mental health treatments into residents' aged care plan, including adequate access to multidisciplinary mental health teams that include psychiatrists, psychologists and social workers.

Aged care's division of governance

In order for the aged care system to evolve we must also consider that, like the broader health system, aged care impacts upon state, territory, and Federal Government. However, there is a lack of coordination between the levels of jurisdiction. Aged care is the purview of the Commonwealth but when a health complication arises, residents are often transferred to a hospital which is the responsibility of the State or Territory Government. This means that the States often bear a financial cost resulting from issues that arise in a Commonwealth-run aged care environment.

The federal government is both the regulator of, and an important source of revenue for, aged care providers[40]. RACFs in Australia are owned by not-for-profit providers (57 per cent), for-profit providers (36 per cent), and state and territory local governments (11 per cent)[41]. Although regulated by the Federal Government, state and territory governments still play an

[37] http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129544771
[38] http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129552306
[39] http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-fact-pat
[40] Aged Care Financing Authority (2016) *Fourth report of the funding and financing of the aged care sector.* p2
[41] Aged Care Financing Authority (2016) *Fourth report of the funding and financing of the aged care sector.* p77

important role in providing and funding aged care services[42]. There is no overarching body for the whole aged care sector. This can create confusion for aged care providers when working out who is ultimately responsible.

The Oakden report[43] outlined that there was a lack of leadership and responsibility that led to its multiple problems. There was a lack of awareness and structure of Clinical Governance within the facility and who was ultimately in charge and accountable for issues. Even when issues were raised, staff were bullied and harassed into silence. Our members report that this often occurs in aged care facilities – where staff are not aware of who is ultimately responsible for them. There needs to be increased communication between governments and RACFs to ensure they have an authority figure to report on any aspects of running an aged care facility.

As part of significant reform currently underway, the Department of Health should re-introduce an Aged Care Commissioner. The aged care sector (both government and non-government funded) needs an overarching body that provides a clear, well-communicated, governance hierarchy implemented so aged care service providers are aware of their responsibilities, and who is responsible for them.

Conclusion

Both the Government and the aged care sector need to recognise that older Australians have a right to the same access to healthcare as their younger counterparts, and access to medical care should be reflected both in specific clinical accreditation standards and through the implementation of proper incentives and environments for medical practitioners to practise within RACFs.

The Australian aged care system is heavily regulated and, with reform underway, regulation may increase over time. Without adequate financial support, guidance, and accountability from the Government, RACFs and other aged care services will continue to struggle to meet these complex regulations. Regulation alone is not the solution – RACFs need to focus on the important determinants of quality care, and operate within a governance structure and framework that encourages and rewards quality rather than spending substantial time documenting and complying with unnecessary regulation.

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[42]Community Affairs References Committee (2017) *Future of Australia's aged care* workforce. p17
[43]Groves A, Thomson D, McKellar D and Procter N. (2017) *The Oakden Report.* Adelaide, South Australia: SA Health, Department for Health and Ageing. p75.